Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003273	A. BUILDING _____ B. WING _____	R 02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 1/9/13. Survey date: 2/14/13 Facility number: 003273 Provider number: 003273 Survey team: Tim Long, RN, TC Diane Nilson, RN Carol Miller, RN Census bed type: Residential: 53 Total: 53 Census Payor type: Other: 53 Total: 53 Sample: 6 Emeritus at Fort Wayne was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the State Residential Licensure Survey. Quality review completed on February 15, 2013 by Randy Fry RN.	{R 000}		